		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044347

Facility Name: BLOOMINGDALE PAVILION, LLC

Address: 311 EDGEWATER DRIVE (Number) BLOOMINGDALE (City) 60108 (Zip Code)

County: DUPAGE

Telephone Number: 630 894-7400 **Fax #** 630 894-8528

IDPA ID Number: 36-4214316-001

Date of Initial License for Current Owners: 5/1/98

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[X]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) MARVIN FOX, C.P.A.

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	259	Skilled (SNF)	259	94,794	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	259	TOTALS	259	94,794	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	19,492	5,166	7,659	32,317	8
9	SNF/PED					9
10	ICF	36,349	9,800		46,149	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	55,841	14,966	7,659	78,466	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.78%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 30 and days of care provided 7,189

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	309,006	31,437	9,208	349,651		349,651	15,534	365,185			1
2	Food Purchase		333,415		333,415	(34,587)	298,828	(634)	298,194			2
3	Housekeeping	113,634	37,344	127,020	277,998		277,998		277,998			3
4	Laundry	48,442	33,548	70,618	152,608		152,608		152,608			4
5	Heat and Other Utilities			194,609	194,609		194,609	2,045	196,654			5
6	Maintenance	129,631		146,914	276,545		276,545	5,141	281,686			6
7	Other (specify):*							4,968	4,968			7
8	**TOTAL General Services**	600,713	435,744	548,369	1,584,826	(34,587)	1,550,239	27,054	1,577,293			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	3,195,060	182,458	783,571	4,161,089		4,161,089	(12,795)	4,148,294			10
10a	Therapy	123,739	12,984	16,970	153,693		153,693	(1,201)	152,492			10a
11	Activities	202,144	18,443	2,453	223,040		223,040		223,040			11
12	Social Services	62,482		2,745	65,227		65,227		65,227			12
13	Nurse Aide Training											13
14	Program Transportation	7,387		75	7,462		7,462		7,462			14
15	Other (specify):*							6,346	6,346			15
16	**TOTAL Health Care and Programs**	3,590,812	213,885	810,614	4,615,311		4,615,311	(7,650)	4,607,661			16
	C. General Administration											
17	Administrative	115,399		439,685	555,084		555,084	(273,703)	281,381			17
18	Directors Fees											18
19	Professional Services			89,881	89,881	(750)	89,131	471	89,602			19
20	Dues, Fees, Subscriptions & Promotions			102,979	102,979		102,979	(44,697)	58,282			20
21	Clerical & General Office Expenses	128,397	62,455	#VALUE!	#VALUE!		#VALUE!	3,961	#VALUE!			21
22	Employee Benefits & Payroll Taxes			714,528	714,528	34,587	749,115	(62)	749,053			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,197	1,197		1,197	857	2,054			24
25	Other Admin. Staff Transportation			1,788	1,788		1,788	2,728	4,516			25
26	Insurance-Prop.Liab.Malpractice			145,388	145,388		145,388	108	145,496			26
27	Other (specify):*							45,012	45,012			27
28	**TOTAL General Administration**	243,796	62,455	#VALUE!	#VALUE!	33,837	#VALUE!	(265,325)	#VALUE!			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,435,321	712,084	#VALUE!	#VALUE!	(750)	#VALUE!	(245,921)	#VALUE!			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

BLOOMINGDALE PAVILION, LLC
0044347
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	34,587	
2	FOOD		34,587

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	750	
19	PROFESSIONAL FEES		750

To reclass cost of appealing real estate taxes

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC #0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			86,004	86,004		86,004	(16,682)	69,322			30
31	Amortization of Pre-Op. & Org.			13,147	13,147		13,147		13,147			31
32	Interest			301,810	301,810		301,810	7,589	309,399			32
33	Real Estate Taxes			#VALUE!	#VALUE!	750	#VALUE!		#VALUE!			33
34	Rent-Facility & Grounds			1,563,902	1,563,902		1,563,902	17,716	1,581,618			34
35	Rent-Equipment & Vehicles			16,742	16,742		16,742	2,127	18,869			35
36	Other (specify):*											36
37	**TOTAL Ownership**			#VALUE!	#VALUE!	750	#VALUE!	10,750	#VALUE!			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	112,451	539,360	802,017	1,453,828		1,453,828	(112,800)	1,341,028			39
40	Barber and Beauty Shops	3,879			3,879		3,879	(3,879)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			142,192	142,192		142,192		142,192			42
43	Other (specify):*	53,629			53,629		53,629	(53,629)				43
44	**TOTAL Special Cost Centers**	169,959	539,360	944,209	1,653,528		1,653,528	(170,308)	1,483,220			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,605,280	1,251,444	#VALUE!	#VALUE!		#VALUE!	(405,479)	#VALUE!			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(49,440)	30		9
10	Interest and Other Investment Income	(779)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(634)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,200)	21		18
19	Entertainment	(881)	21		19
20	Contributions	(3,500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(102,563)	21		24
25	Fund Raising, Advertising and Promotional	(32,823)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(12,961)	20		28
29	Other-Attach Schedule	(129,294)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (341,075)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(64,404)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (64,404)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (405,479)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

BLOOMINGDALE PAVILION, LLC

ID# 0044347

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	TRUST FEES	(300)	20	2
3	IL COUNCIL POLITICAL PORTION DUES	(298)	20	3
4	MARKETING SALARIES	(53,501)	43	4
5	LEGAL RELATED TO NON-CARE SERVICES	(3,915)	19	5
6	UNIDENTIFIABLE LEGAL INVOICE	(511)	19	6
7	CAPITALIZED R&M	(11,272)	6	7
8	MARKETING BONUS	(50)	43	8
9	MARKETING TRAVEL	(78)	43	9
10	BANK CHARGES	(55,398)	21	10
11	BEAUTICIAN SALARY	(3,879)	40	11
12	HOLIDAY EXPENSE	(62)	22	12
13	MARKETING SEMINAR	(30)	24	13
14				14
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89				89
90	Total	(129,294)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses A. General Services	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
1	Dietary				401	15,133							15,534	1
2	Food Purchase	(634)											(634)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			2,045									2,045	5
6	Maintenance	(11,272)		700	15,713								5,141	6
7	Other (specify):*				4,968								4,968	7
8	**TOTAL General Services**	(11,906)		2,745	21,082	15,133							27,054	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			39,529		(52,324)							(12,795)	10
10a	Therapy						(1,201)						(1,201)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			6,346									6,346	15
16	**TOTAL Health Care and Programs**			45,875		(52,324)	(1,201)						(7,650)	16
	C. General Administration													
17	Administrative			(273,703)									(273,703)	17
18	Directors Fees													18
19	Professional Services	(4,426)		4,897									471	19
20	Fees, Subscriptions & Promotions	(49,882)		5,185									(44,697)	20
21	Clerical & General Office Expenses	(167,042)		171,003									3,961	21
22	Employee Benefits & Payroll Taxes	(62)											(62)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(30)		887									857	24
25	Other Admin. Staff Transportation			2,728									2,728	25
26	Insurance-Prop.Liab.Malpractice			108									108	26
27	Other (specify):*			45,012									45,012	27
28	**TOTAL General Administration**	(221,442)		(43,883)									(265,325)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(233,348)		4,737	21,082	(37,191)	(1,201)						(245,921)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(49,440)		32,758									(16,682)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(779)		8,368									7,589	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds			17,716									17,716	34
35	Rent-Equipment & Vehicles			2,127									2,127	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(50,219)		60,969									10,750	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(18,643)	(94,157)						(112,800)	39
40	Barber and Beauty Shops	(3,879)											(3,879)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(53,629)											(53,629)	43
44	**TOTAL Special Cost Centers**	(57,508)				(18,643)	(94,157)						(170,308)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(341,075)		65,706	21,082	(55,834)	(95,358)						(405,479)	45

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	QUALITY CARE MANAGEMENT	100.00%	$ 2,045	$ 2,045	15
16	V	6	REPAIRS AND MAINT.		QUALITY CARE MANAGEMENT	100.00%	700	700	16
17	V	10	SAL-NURSING		QUALITY CARE MANAGEMENT	100.00%	39,529	39,529	17
18	V	15	EMP. BEN.-H.C.		QUALITY CARE MANAGEMENT	100.00%	6,346	6,346	18
19	V	17	ADMIN SAL-NON-OWNER		QUALITY CARE MANAGEMENT	100.00%	7,149	7,149	19
20	V	17	ADMIN. SAL.- A. SALTZMAN		QUALITY CARE MANAGEMENT	100.00%	28,694	28,694	20
21	V	17	ADMIN. SAL - B BENOUDIZ		QUALITY CARE MANAGEMENT	100.00%	27,659	27,659	21
22	V	17	ADMIN. SAL. - B. CLOCH		QUALITY CARE MANAGEMENT	100.00%	69,364	69,364	22
23	V	17	ADMIN. SAL. - B. TEITELBAUM		QUALITY CARE MANAGEMENT	100.00%	7,546	7,546	23
24	V	17	ADMIN. SAL - J. MEISELS		QUALITY CARE MANAGEMENT	100.00%	3,105	3,105	24
25	V	17	ADMIN. SAL. - MIKE FILIPPO		QUALITY CARE MANAGEMENT	100.00%	22,468	22,468	25
26	V	19	PROFESSIONAL FEES		QUALITY CARE MANAGEMENT	100.00%	4,897	4,897	26
27	V	20	FEES,SUBSCRIPTIONS		QUALITY CARE MANAGEMENT	100.00%	5,185	5,185	27
28	V	21	CLERICAL & GENERAL		QUALITY CARE MANAGEMENT	100.00%	171,003	171,003	28
29	V	24	EDUCATION & SEMINAR		QUALITY CARE MANAGEMENT	100.00%	887	887	29
30	V	25	OTHER ADMIN. STAFF TRANS.		QUALITY CARE MANAGEMENT	100.00%	2,728	2,728	30
31	V	26	INSURANCE		QUALITY CARE MANAGEMENT	100.00%	108	108	31
32	V	27	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	45,012	45,012	32
33	V	30	DEPRECIATION		QUALITY CARE MANAGEMENT	100.00%	32,758	32,758	33
34	V	32	INTEREST		QUALITY CARE MANAGEMENT	100.00%	8,368	8,368	34
35	V	34	OFFICE RENT-UNRELATED		QUALITY CARE MANAGEMENT	100.00%	17,716	17,716	35
36	V	35	EQUIPMENT RENTAL		QUALITY CARE MANAGEMENT	100.00%	2,127	2,127	36
37	V								37
38	V	17	CORPORATE ALLOCATION	439,688	QUALITY CARE MANAGEMENT	100.00%		(439,688)	38
39	Total			$ 439,688			$ 505,394	$ * 65,706	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS AND MAINT.	$ 10,064	QUALITY CARE MANAGEMENT	100.00%	$ 25,777	$ 15,713	15
16	V	7	EMP. BEN.-GEN. SERV.		QUALITY CARE MANAGEMENT	100.00%	4,138	4,138	16
17	V								17
18	V	1	DIETICIAN SALARIES	4,770	QUALITY CARE MANAGEMENT	100.00%	5,171	401	18
19	V	7	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	830	830	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 14,834			$ 35,916	$ * 21,082	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	MEDICAL/TUBE FEED-MDCR	$ 29,480	QUALITY CARE MEDICAL SUPPLY	100.00%	$ 10,837	$ (18,643)	15
16	V	10	MEDICAL SUPPLIES	58,809	QUALITY CARE MEDICAL SUPPLY	100.00%	6,485	(52,324)	16
17	V	1	FOOD SUPPLEMENTS		QUALITY CARE MEDICAL SUPPLY	100.00%	15,133	15,133	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 88,289			$ 32,455	$ * (55,834)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	REHAB CONSULTING	$ 7,106	ADVANCED THERAPY & REHAB, L.L.C.	100.00%	$ 5,905	$ (1,201)	15
16	V	39	ANCILLARY REHAB	557,141	ADVANCED THERAPY & REHAB, L.L.C.	100.00%	462,984	(94,157)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 564,247			$ 468,889	$ * (95,358)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BRIAN CLOCH	OWNER	Administrative	0.50	SEE ATTACHED	9.16	0.14	Alloc Quality	$ 69,364	17-7	1
2	DAVID MEISELS	OWNER	Administrative	0.50	SEE ATTACHED	5	0.09				2
3	BRUCHA TEITELBAUM	Administrative	Administrative		SEE ATTACHED	1.1	0.03	Alloc Quality	7,546	17-7	3
4	JOSEPH MEISELS	Administrative	Administrative		SEE ATTACHED	4.4	0.09	Alloc Quality	3,105	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 80,015		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	352,747	6	$ 9,193	$	78,466	$ 2,045	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	352,747	6	3,145		78,466	700	2
3	10	SAL-NURSING	PATIENT DAYS	352,747	6	177,703	177,703	78,466	39,529	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	352,747	6	28,527		78,466	6,346	4
5	17	ADMIN SAL-NON-OWNER	PATIENT DAYS	352,747	6	32,137	32,137	78,466	7,149	5
6	17	ADMIN. SAL.- A. SALTZMAN	PATIENT DAYS	352,747	6	128,995	128,995	78,466	28,694	6
7	17	ADMIN. SAL - B BENOUDIZ	PATIENT DAYS	352,747	6	124,342	124,342	78,466	27,659	7
8	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	352,747	6	311,829	311,829	78,466	69,364	8
9	17	ADMIN. SAL. - B. TEITELBAUN	PATIENT DAYS	352,747	6	33,925	33,925	78,466	7,546	9
10	17	ADMIN. SAL - J. MEISELS	PATIENT DAYS	352,747	6	13,958	13,958	78,466	3,105	10
11	17	ADMIN. SAL. - MIKE FILIPPO	PATIENT DAYS	352,747	6	101,006	101,006	78,466	22,468	11
12	19	PROFESSIONAL FEES	PATIENT DAYS	352,747	6	22,013		78,466	4,897	12
13	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	352,747	6	23,307		78,466	5,185	13
14	21	CLERICAL & GENERAL	PATIENT DAYS	352,747	6	768,752	651,494	78,466	171,003	14
15	24	EDUCATION & SEMINAR	PATIENT DAYS	352,747	6	3,989		78,466	887	15
16	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	352,747	6	12,263		78,466	2,728	16
17	26	INSURANCE	PATIENT DAYS	352,747	6	485		78,466	108	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	352,747	6	202,353		78,466	45,012	18
19	30	DEPRECIATION	PATIENT DAYS	352,747	6	147,266		78,466	32,758	19
20	32	INTEREST	PATIENT DAYS	352,747	6	37,619		78,466	8,368	20
21	34	OFFICE RENT-UNRELATED	PATIENT DAYS	352,747	6	79,644		78,466	17,716	21
22	35	EQUIPMENT RENTAL	PATIENT DAYS	352,747	6	9,564		78,466	2,127	22
23										23
24										24
25	TOTALS					$ 2,272,015	$ 1,575,389		$ 505,394	25

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	REPAIRS AND MAINT.	PAINTING REVENUE	21,912	5	$ 56,124	$ 56,124	10,064	$ 25,777	1
2	7	EMP. BEN.-GEN. SERV.	PAINTING REVENUE	21,912	5	9,010		10,064	4,138	2
3										3
4	1	DIETICIAN SALARIES	DIETICIAN REVENUE	18,893	6	20,480	20,480	4,770	5,171	4
5	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN REVENUE	18,893	6	$ 3,288	$	4,770	$ 830	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 88,902	$ 76,604		$ 35,916	25

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MEDICAL SUPPLY
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	MEDICAL/TUBE FEED-MDCR	DIRECT ALLOCATION						10,837	1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						6,485	2
3	1	FOOD SUPPLEMENTS	DIRECT ALLOCATION						15,133	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 32,455	25

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Advanced Therapy & Rehab., L.L.C.
Street Address: 8950 Gross Point Rd. #E
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	REHAB CONSULTING	DIRECT ALLOCATION						5,905	1
2	39	ANCILLARY REHAB	DIRECT ALLOCATION						462,984	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 468,889	25

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Manufacturer's Bank		x	Working Capital	varies	5/28/98	900,000	531,908	demand	prm+1%	67,098	6
7	Yeshiva		x	Working Capital			800,000	800,000	demand	8.0000	64,000	7
8	Corus Bank		x	Working Capital	Int Only	7/15/98	1,500,000	1,500,000	demand	prm+.5%	145,426	8
9	TOTAL Facility Related						$ 3,200,000	$ 2,831,908			$ 276,524	9
	B. Non-Facility Related*											
10	Supplemental Schedule							374,684			33,654	10
11	INTEREST INCOME										(779)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$ 374,684			$ 32,875	14
15	TOTALS (line 9+line14)						$ 3,200,000	$ 3,206,592			$ 309,399	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	BANK LEUMI		X	WORKING CAPITAL	VARIES	05/24/00	$ 400,000	$ 367,105	06/01/03	PRM+.5%	$ 24,504	1
2	HILL ROM		X	EQUIPMENT	1,554.00	05/01/00	18,647	7,579	05/01/01	10.00%	781	2
3	Allocation Quality Care Mgmt	X									8,369	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$ 418,647	$ 374,684			$ 33,654	21

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	175,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	169,114	2
3. Under or (over) accrual (line 2 minus line 1).	$	(5,886)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	175,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.	$	750	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	169,864	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996		9
1997		10
1998	113,308	11
1999	169,114	12

2000 ACCRUAL 169114*1.03%=175,000 (ROUNDING)

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,047 B. General Construction Type: Exterior MASONRY Frame _____ Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 35,737
2. Number of Years Over Which it is Being Amortized: 5 YEARS, 1 YEAR
3. Current Period Amortization: 13,147
4. Dates Incurred: 5/01/98

Nature of Costs: ORGANIZATION COSTS ; UNAMORTIZED LINE OF CREDIT
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CARPETING			1998	9,156	235	20	458	223	1,107	9
10	EMERGENCY PANEL			1998	12,000	308	20	600	292	1,300	10
11	FLOOR TILES			1998	1,740		20	87	87	174	11
12	TILE			1998	821	21	20	41	20	99	12
13	PULL STATION			1998	1,335	34	20	67	33	162	13
14	WIRING			1998	2,200	56	20	110	54	266	14
15	WALLPAPER			1998	3,542	91	20	177	86	443	15
16	WALLPAPER			1998	4,839	124	20	242	118	565	16
17	WALLPAPER			1998	849	22	20	42	20	105	17
18	PAINTING & DECORATE			1998	5,985		20	299	299	623	18
19	NURSES STATION			1998	9,819	252	20	491	239	1,146	19
20	ELECTRICAL WORK			1998	2,265	58	20	113	55	254	20
21	HANDRAILS			1998	3,364	86	20	168	82	420	21
22	ROOF REPAIRS			1998	3,595	92	20	180	88	375	22
23	WALLPAPER			1998	2,166	56	20	108	52	234	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	PAGE 12B TOTALS				44,429	3,367		3,631	264	3,631	34
35	PAGE 12A TOTALS				95,013	2,746		4,926	2,180	7,599	35
36	TOTAL (lines 4 thru 35)				$ 203,118	$ 7,548		$ 11,740	$ 4,192	$ 18,503	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CARPET INSTALL			1998	2,511	64	20	126	62	273	9
10	HAND RAILS			1998	11,299	290	20	565	275	1,271	10
11	CARPETING			1998	3,202	82	20	160	78	360	11
12	CARPETING			1999	3,218	83	20	161	78	322	12
13	WALLPAPER			1999	1,397	36	20	70	34	88	13
14	FIRE ALARM WORK			1999	6,105	157	20	305	148	458	14
15	FIRE ALARM WORK			1999	4,013	103	20	201	98	402	15
16	AC COMPRESSOR			1999	3,286	84	20	164	80	260	16
17	OUTDOOR SHED			1999	1,277	33	20	64	31	91	17
18	FENCE			1999	1,705	44	20	85	41	135	18
19	HANDRAILS			1999	15,358	394	20	768	374	960	19
20	COVE BASE			1999	701	18	20	35	17	47	20
21	WALLCOVERINGS			1999	962	25	20	48	23	64	21
22	HAND RAILS			1999	15,358	394	20	768	374	1,024	22
23	SHED MATERIALS			1999	1,357	35	20	68	33	91	23
24	FIRE DOOR			1999	1,348	35	20	67	32	123	24
25	FIBERGLASS WALLCOVER			1999	1,178		20	59	59	64	25
26	WALLPAPER			1999	966	25	20	48	23	64	26
27	WALLPAPER			1999	5,319	136	20	266	130	333	27
28	ELECTRICAL WORK			1999	985	25	20	49	24	57	28
29	GENERATOR REPAIRS			1999	1,346		20	67	67	89	29
30	PAINTING & DEC			1999	3,049		20	152	152	228	30
31	WANDERGUARD MONITOR			1999	1,049	272	20	52	(220)	100	31
32	FIRE ALARM SYSTEM			1999	5,500	141	20	275	134	367	32
33	GENERATOR WIRING			1999	709	18	20	35	17	41	33
34	ELEC OUTLETS			1999	635	16	20	32	16	51	34
35	WALL COVERING			2000	1,180	236	20	236		236	35
36	TOTAL (lines 4 thru 35)				$ 95,013	$ 2,746		$ 4,926	$ 2,180	$ 7,599	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WALLPAPER			2000	888		20	44	44	44	9
10	COMPRESSOR			2000	1,613		20	81	81	81	10
11	BOILER			2000	1,000	8	20	8		8	11
12	ELECTRIC WIRING			2000	2,077	33	20	33		33	12
13	BORDER			2000	507	102	20	102		102	13
14	HANDRAIL			2000	2,000	40	20	40		40	14
15	MIRRORS			2000	700	140	20	140		140	15
16	BORDER			2000	834	167	20	167		167	16
17	MIRRORS			2000	674	135	20	135		135	17
18	FLOORING			2000	10,111	248	20	248		248	18
19	FLOOR TILE			2000	1,074	27	20	27		27	19
20	SPRINKLER			2000	1,050	24	20	24		24	20
21	DOORS			2000	1,278	10	20	10		10	21
22	INTERCOM SYSTEM			2000	3,855	12	20	12		12	22
23	PAGING SYSTEM			2000	1,178	1	20	1		1	23
24	WALLCOVERINGS			2000	1,179	236	20	236		236	24
25	ROOFING			2000	525		20	26	26	26	25
26	CUBICLE CURTAINS			2000	515		20	25	25	25	26
27	DOOR			2000	718	5	20	5		5	27
28	WALLCOVERING			2000	935		20	47	47	47	28
29	WINDOW TREATMENT			2000	1,474	295	20	295		295	29
30	INTERIOR SIGNAGE			2000	3,687	738	20	738		738	30
31	COVE BASE			2000	829		20	41	41	41	31
32	KEYPAD ENTRY SYSTEM			2000	5,146	1,029	20	1,029		1,029	32
33	INST MIRRORS			2000	582	117	20	117		117	33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 44,429	$ 3,367		$ 3,631	$ 264	$ 3,631	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
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	Improvement Type**										
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
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8											8
	Improvement Type**										
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31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
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	Improvement Type**										
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
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	Improvement Type**										
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31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
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	Improvement Type**										
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 355,674	$ 99,579	$ 45,643	$ (53,936)		$ 95,787	37
38	Current Year Purchases	64,927	11,636	11,940	304		11,940	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 420,601	$ 111,215	$ 57,583	$ (53,632)		$ 107,727	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 623,719	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 118,763	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 69,323	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (49,440)	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 126,230	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58	ASSISTED LIVING PROJECT	$ 19,922	58
59			59
60			60
61		$ 19,922	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

BLOOMINGDALE PAVILION, LLC
0044347
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

LINE 28: PRIOR YEARS

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
BLOOMINGDALE PAVILION, LLC.	249,546	67,215	35,029	(32,186)	76,598
QUALITY CARE MANAGEMENT	106,128	32,364	10,614	(21,750)	19,189
TOTALS	355,674	99,579	45,643	(53,936)	95,787

LINE 29: CURRENT YEAR

BLOOMINGDALE PAVILION, LLC.	62,146	11,241	11,837	596	11,837
QUALITY CARE MANAGEMENT	2,781	395	103	(292)	103
TOTALS	64,927	11,636	11,940	304	11,940

LINE 30: FULLY DEPRECIATED

BLOOMINGDALE PAVILION, LLC.					
QUALITY CARE MANAGEMENT					
TOTALS					

TOTALS (Should Tie to Totals on Page 13)

BLOOMINGDALE PAVILION, LLC.	311,692	78,456	46,866	(31,590)	88,435
QUALITY CARE MANAGEMENT	108,909	32,759	10,717	(22,042)	19,292
TOTALS	420,601	111,215	57,583	(53,632)	107,727

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: TRUST No. 10-30397-09

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		259	05/01/98	$ 1,559,828			3
4	Additions							4
5	STORAGE				4,074			5
6	QUALITY CARE MGMT ALLOCATION				17,716			6
7	TOTAL		259		$ 1,581,618 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: [X] YES [ ] NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning 05/01/98
Ending 12/31/11

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$ 1,607,095
13.	/2002	$ 1,630,729
14.	/2003	$ 1,663,816

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 18,868 Description: COPIER $13828; ICE MAKER $900; WATER MACHINE $2013; ALLOC FROM QUALITY CARE $2127
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$ 0	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 25,437	$		$ 25,437	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			12,146			12,146	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			569,101			569,101	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				145,840		145,840	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**	39-2, 39-3				213,625	374,877		588,502	13
14	TOTAL			$		$ 820,309	$ 520,717		$ 1,341,026	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	I.V. Expense	763
2	Radiology Expense	7,546
3	Tube Expense	10,837
4	Oxygen Expense	99,323
5	Respiratory Therapy Supplies	175,960
6	Lab Expense	12,572
7	Air Fluidized Beds	67,838
8	Medical Supplies	38
9		
10		
		374,877

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy Salary	112,451
2	Respiratory Therapy Expense	101,174
3		
4		
5		
6		
7		
8		
9		
10		
		213,625

STATE OF ILLINOIS

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,100	$	1
2	Cash-Patient Deposits	56,328		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,612,741		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	63,318		6
7	Other Prepaid Expenses	228,077		7
8	Accounts Receivable (owners or related parties)	3,266		8
9	Other(specify): See supplemental schedule	280,132		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,244,962	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	178,298		15
16	Equipment, at Historical Cost	311,929		16
17	Accumulated Depreciation (book methods)	(185,073)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	18,177		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	1,118,522		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,441,853	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,686,815	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,018,610	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	56,386		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	183,201		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,215		31
32	Accrued Real Estate Taxes(Sch.IX-B)	175,000		32
33	Accrued Interest Payable	50,827		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	31,967		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,536,206	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,206,592		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,206,592	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,742,798	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ #VALUE!	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ #VALUE!	$ #REF!	48

*(See instructions.)

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC **#** 0044347 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
EMPLOYEE ADVANCES	60,592	
INTEREST RECEIVABLE	2,935	
DUE FROM OTHERS	5,650	
R/E ESCROW	202,044	
DUE PRG	5,000	
DUE FROM MEDICARE	3,911	
	280,132	

OTHER CURRENT LIABILITIES:	Amount	Amount
DUE QUALITY CARE MANAGEMENT	31,967	
Accrued R. E. Tax - Non Care Property		
	31,967	

OTHER NON CURRENT ASSETS:		
ASSISTED LIVING PROJECT	19,922	
OPTION DEPOSIT	1,098,600	
Loan Costs		
	1,118,522	

OTHER NON CURRENT LIABILITIES:

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (99,784)	1
2	Restatements (describe):		2
3	Schedule attached		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (99,784)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	#VALUE!	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ #VALUE!	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ #VALUE!	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	BLOOMINGDALE PAVILION, LLC	#	0044347	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		(99,784)
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		(99,784)
Equity(Deficit) from Page 17 Col 1		#VALUE!
Related Party		
Equity(Deficit)	0	
Income	0	
		-
Combined Equity - End of Year		#VALUE!

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,238,397	1
2	Discounts and Allowances for all Levels	(2,956,474)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,281,923	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,904,783	6
7	Oxygen	184,067	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,088,850	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,959	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	226,239	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	45,369	19
20	Radiology and X-Ray	9,090	20
21	Other Medical Services	418,072	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 702,729	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	779	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 779	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,074,281	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,584,826	31
32	Health Care	4,615,311	32
33	General Administration	#VALUE!	33
	B. Capital Expense		
34	Ownership	#VALUE!	34
	C. Ancillary Expense		
35	Special Cost Centers	1,511,336	35
36	Provider Participation Fee	142,192	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ #VALUE!	40
41	**Income before Income Taxes (line 30 minus line 40)****	#VALUE!	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ #VALUE!	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not completed If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,455	1,712	$ 50,300	$ 29.38	1
2	Assistant Director of Nursing	1,752	1,970	47,610	24.17	2
3	Registered Nurses	45,858	56,340	1,026,759	18.22	3
4	Licensed Practical Nurses	22,917	25,129	472,316	18.80	4
5	Nurse Aides & Orderlies	115,427	141,060	1,537,242	10.90	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	5,541	5,689	112,451	19.77	7
8	Rehab/Therapy Aides	8,045	9,115	123,739	13.58	8
9	Activity Director	1,785	2,091	34,141	16.33	9
10	Activity Assistants	14,348	16,258	168,003	10.33	10
11	Social Service Workers	4,627	4,879	62,482	12.81	11
12	Dietician					12
13	Food Service Supervisor	1,674	1,724	27,425	15.91	13
14	Head Cook					14
15	Cook Helpers/Assistants	30,090	33,074	281,581	8.51	15
16	Dishwashers					16
17	Maintenance Workers	8,520	8,962	129,631	14.46	17
18	Housekeepers	15,346	16,294	113,634	6.97	18
19	Laundry	6,968	7,696	48,442	6.29	19
20	Administrator	2,153	2,387	79,155	33.16	20
21	Assistant Administrator	1,737	2,011	36,244	18.02	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,859	16,793	128,397	7.65	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	23,324	6,474	60,833	9.40	31
32	Other Health Care(specify)					32
33	Other(specify)	2,878	3,444	64,895	18.84	33
34	TOTAL (lines 1 - 33)	329,304	363,102	$ 4,605,280 *	$ 12.68	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	262	$ 9,208	1-3	35
36	Medical Director	96	4,800	9-3	36
37	Medical Records Consultant	23	1,150	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	216	7,560	10-3	39
40	Physical Therapy Consultant	147	6,850	10A-3	40
41	Occupational Therapy Consultant	90	4,120	10A-3	41
42	Respiratory Therapy Consultant	120	6,000	10A-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	45	2,453	11-3	44
45	Social Service Consultant	61	2,745	12-3	45
46	Other(specify)				46
47	ALZHEIMER CONSULTANT	16	775	10-3	47
48	WOUND CARE	28	3,050	10-3	48
49	TOTAL (lines 35 - 48)	1,104	$ 48,711		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides		771,036	10-3	52
53	TOTAL (lines 50 - 52)		$ 771,036		53

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
VAN DRIVER	589	905	$ 7,387	$ 8.16
MARKETING SALARIES	1,913	2,163	53,629	24.79
BEAUTICIAN	376	376	3,879	10.32
	2,878	3,444	$ 64,895	$ 18.84

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
LAURA KELLY 1/11-8/2/00	ADMINISTRATOR	0	46,148
WILLIAM PFIEFFER 8/3-12/31/00	ADMINISTRATOR	0	33,007
GREG KENNEDY 1/1-11/6/00	ASSIST ADMIN	0	36,244
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 115,399

B. Administrative - Other

Description	Amount
QUALITY CARE MANAGEMENT (corporate allocation)	$ 329,764
QUALITY CARE MANAGEMENT (Administartive Consultant)	109,921
TOTAL (agree to Schedule V, line 17, col. 3)	$ 439,685
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R	ACCOUNTING	$ 21,209
COMMITMENT CONSULTING	A/R CONSULTANT	135
HEALTH DATA SYSTEMS	COMPUTER SERVICE	10,764
ZIMMERMAN R/E GROUP	R/E APPRAISAL FEE	750
PERSONNEL PLANNERS	UNEMPLOYMENT CNSLT	1,199
LEGAL (SEE ATTACHED)	LEGAL	52,338
ACCUMED	COMPUTER SERVICE	3,381
QUALITY CARE MANAGEMNT	COMPUTER SERVICE	105
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 89,881

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 65,334
Unemployment Compensation Insurance	76,351
FICA Taxes	332,782
Employee Health Insurance	185,017
Employee Meals	34,587
Illinois Municipal Retirement Fund (IMRF)*	
401K EXPENSE	16,223
EMPLOYEE BENEFITS	36,781
HOLIDAY EXPENSE	1,977
TOTAL (agree to Schedule V, line 22, col.8)	$ 749,052

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	4,627
Health Care Worker Background Check	
(Indicate # of checks performed 15)	180
DUES AND SUBSCRIPTIONS	1,095
DUES ILCLTC	9,778
PROMOTIONAL ADVERTISING	71,739
Allocated form Quality Care Mgmt	5,185
YELLOW PAGE	12,961
LICENSE AND FEES	1,801
Less: Public Relations Expense	(3,500)
Non-allowable advertising	(32,823)
Yellow page advertising	(12,961)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 58,282

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,512
Allocated from Quality Care Mgmt	887
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,399

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BLOOMINGDALE PAVILION, LLC # 0044347 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL ON LONG TERM CARE $10076

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YEARS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 7,954 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 142,191
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 34,587 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 100%L14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12, do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When

paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "All Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu bar after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use File-Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been sealed, you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw